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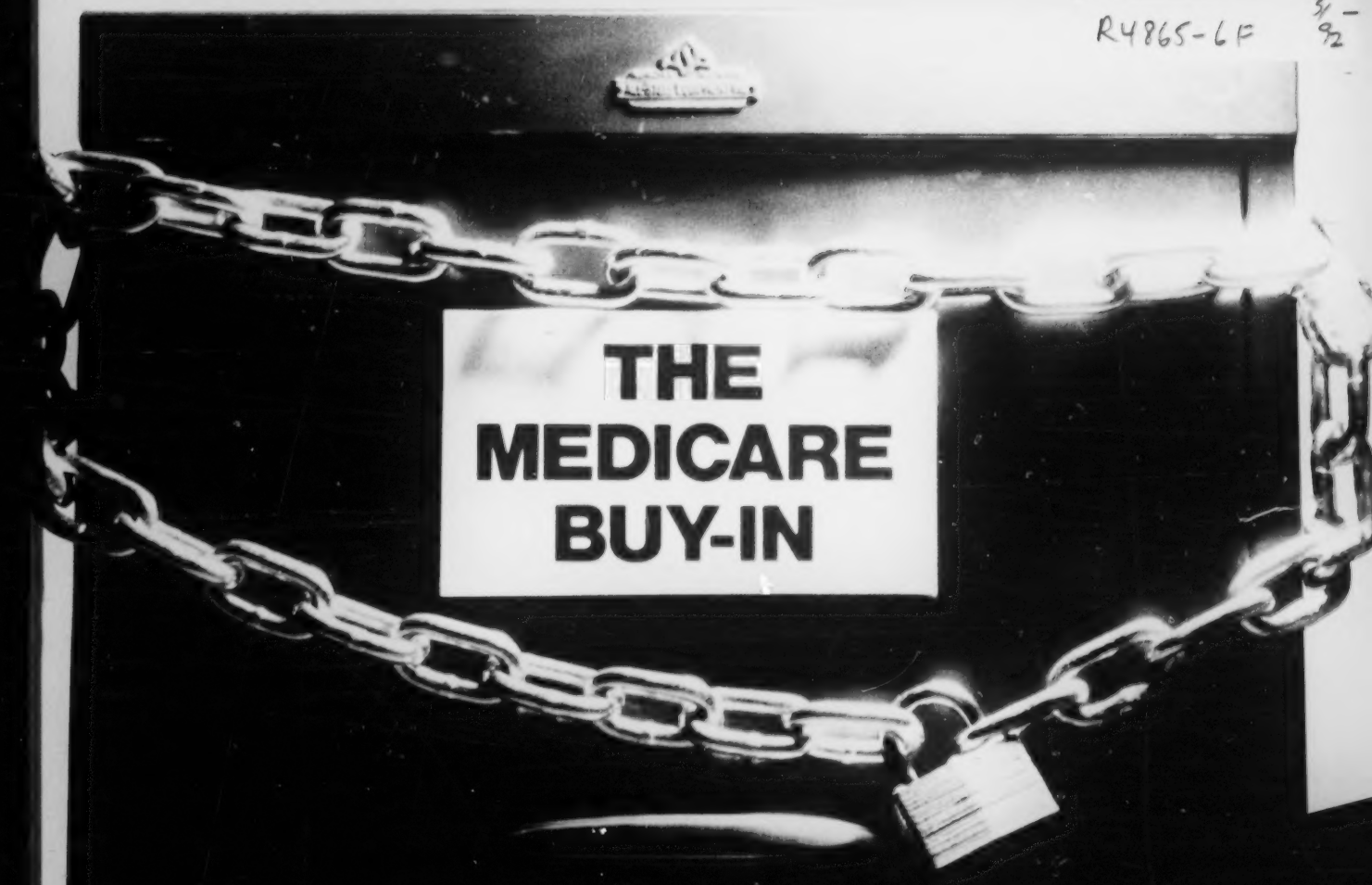

STILL A GOVERNMENT SECRET

A FAMILIES USA REPORT **$5.00**

The Medicare Buy-In: Still A Government Secret

A report by

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Supported in part by a grant from

The Public Welfare Foundation, Inc.

March 1992

Introduction—Key Findings

In June 1991 Families USA released information showing that over half of the poor seniors eligible for the Medicare buy-in benefit, 2.2 to 2.3 million, were not receiving the benefit.

The Medicare buy-in allows poor seniors and persons with disabilities to avoid the substantial out-of-pocket health costs related to Medicare. Those eligible must have incomes below $6,810 and assets of less than $4,000, if single, and incomes below $9,190 and assets of less than $6,000, if married.* These persons are known as Qualified Medicare Beneficiaries, or QMBs.

The Families USA report, ***The Secret Benefit***, received extraordinary media coverage. Major television networks covered the story, some of them airing the story on multiple programs. Radio coverage was equally extensive and included numerous interviews with Families USA staff. Print stories appeared in most daily newspapers and in many more publications aimed specifically at seniors. In addition, Families USA staff handled thousands of telephone inquiries stimulated by the media coverage and sent out thousands of fact sheets about the QMB benefit and how to apply.

Since June 1991, an estimated 152,000 poor seniors, about 4 percent of those eligible, began receiving Medicare buy-in benefits, undoubtedly as a result of the unprecedented publicity. Nevertheless, over 2 million poor seniors remain without the financial protection afforded by the buy-in.

For these impoverished seniors, the federal government continues to deduct Medicare premiums ($31.80 per month for individuals, $63.60 per month for couples) each month out of their Social Security checks, even though they are entitled to have those premiums paid by the Medicaid program. These impoverished seniors are also paying substantial portions of their incomes on physician and hospital bills even though by law they are not responsible for these costs.

▸ The following states now have the highest numbers of poor seniors eligible for buy-in benefits, but not receiving them: California (217,623); New York (153,985); Georgia (125,794); Pennsylvania (121,254); Texas (116,263); Florida (103,134); and Illinois (92,604). (See Table 1.)

▸ The following states now have the highest percentages of poor seniors eligible for buy-in benefits, but not receiving them: Alaska (98%); California (86%); Kansas (75%); North Dakota (71%); Rhode Island (68%); Delaware (67%); Georgia (67%); Montana (67%); and Nebraska (67%). (See Table 1.)

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* The methodology for computing eligibility is comparable to the methodology used in the Supplemental Security Income (SSI) program. That methodology disregards an additional $20 of income per month (or $240 per year) for individuals and couples.

▸ In the following states the numbers of poor seniors getting buy-in benefits increased the least from May 1991 to March 1992: Montana (-3.3%); Alaska (0.1%); the District of Columbia (0.6%); Kansas (1.3%); Massachusetts (1.4%); North Dakota (1.4%); Hawaii (1.7%); and Wisconsin (1.8%). (See Table 2.)

▸ In the following states the percentage of poor seniors getting buy-in benefits increased the most from May 1991 to March 1992: Utah (12.1%); Vermont (8.9%); Oregon (8.5%); Idaho (7.4%); Maine (6.3%); Connecticut (5.8%); and Illinois (5.7%). (See Table 2.)

Background—Medicare Cost-sharing

The Medicare program requires substantial out-of-pocket payments from beneficiaries. In 1992 these cost-sharing requirements are: the premium for physician coverage (Part B of Medicare), $31.80 per month (or $381.60 per year); the Part B deductible, $100 per year; copayments of 20 percent for all physician charges above the $100 annual deductible; physician costs that exceed Medicare's billable rate[1]; a hospital (Part A) deductible of $652 for each hospitalization; substantial copayments for hospitalizations in excess of 60 days; and substantial copayments for skilled nursing care stays longer than 21 days.

Beneficiary premiums, deductibles and copayments have escalated very rapidly in the past decade. A comparison of the 1980 and 1992 costs is illustrative:

	1980	1992	Percentage Increase
Part A Deductible	$ 180.00	$ 652.00	+ 262
Part B Premium	104.40	381.60	+ 266
Part B Deductible	60.00	100.00	+ 67
Part B Copayments	138.00[a]	468.00[b]	+ 239
TOTAL	$482.40	$1,601.60	+ 232

[a] average per beneficiary
[b] estimate based on average 1991 amount adjusted for the increase in health costs

Out-of-pocket costs in 1992, for Medicare beneficiaries with one hospitalization, are **at least** $1,601.60 (assuming such beneficiaries have at least average Part B copayments and not including the costs of the services uncovered by Medicare, such as prescription drugs, long term care and numerous others). In fact, this amount constitutes almost one-fourth of the annual income of individuals with incomes below poverty—their entire income for three months.

Congressional Action

Congress has acted in recent years to prevent the extreme financial hardships that such cost-sharing requirements create for low-income beneficiaries. In the Medicare Catastrophic Coverage Act of 1988, Congress required the Medicaid program, beginning in 1989, to "buy-in" to Medicare low-income seniors and persons with disabilities eligible for Medicare.[2] The law required that Medicaid pay the Medicare premiums, deductibles and copayments for low-income seniors and persons with disabilities eligible for Medicare, and these low-income persons are not responsible for any out-of-pocket costs for Medicare-covered services.

As of January 1, 1989, Congress required buy-in coverage for Medicare beneficiaries with incomes at or below 85 percent of the federal poverty guideline and resources of up to $4,000 for an individual and $6,000 for a couple (excluding the home, and much of the value of a car, personal effects, life insurance and burial spaces).[3] Under the law enacted in 1988, the income eligibility standard for the buy-in increased to 90 percent of the poverty guideline in 1990 and was scheduled to increase to 95 percent of the poverty guideline in 1991 and 100 percent in 1992.

In Fall 1990, when Congress increased Medicare cost-sharing amounts as part of its deficit-reduction package, Congress also acted to protect low-income beneficiaries from these increases. Congress accelerated the buy-in requirement for all poor Medicare beneficiaries with limited resources to 1991, rather than 1992, and added buy-in requirements for Medicare beneficiaries with incomes up to 110 percent of the poverty guideline in 1993 and 120 percent of the poverty guideline in 1995. Medicare beneficiaries with incomes between 100 and 120 percent of the poverty guideline will be eligible for Medicaid payment of Medicare premiums, but not for Medicaid payment of other Medicare cost-sharing.

The Medicare buy-in also provides protection for the relatively small number of seniors and persons with disabilities who did not work long enough to qualify for hospital coverage under Part A of Medicare. For individuals without a sufficient work history, Medicare hospital coverage is only available if they pay a monthly premium of $192—an amount that is unaffordable for the poor. The law makes provision for Medicaid to buy low-income seniors and persons with disabilities into Medicare Part A. This is an important benefit—even for those who previously qualified for Medicaid coverage. Medicare hospital benefits are sometimes more comprehensive than

Medicaid hospital benefits because some states impose strict limits on the number of hospital days covered under Medicaid.[4] In addition, the Medicare payment rate is often more generous than Medicaid hospital payment rates, and Medicare therefore offers better access to hospitals.

Proposed Additional Measures

In response to the large numbers of poor seniors without buy-in benefits reported in ***The Secret Benefit***, a number of members of Congress from both parties have advocated, through proposed legislation and letters to Secretary of Health and Human Services Louis Sullivan, a variety of measures to assure that poor seniors get the buy-in benefits to which they are entitled. President Bush proposed many similar strategies to ensure high participation in his proposed program to provide low-income persons with health insurance vouchers. Ironically, the Bush Administration has opposed such efforts to increase the participation of the poor elderly in the Medicare buy-in.

The following is a summary of key proposals by Members of Congress.

- **Taking applications at Social Security offices**

Many Members have proposed that applications for the buy-in be taken at Social Security offices and for Social Security personnel to be trained to assist seniors with completing these applications. This would make it possible for seniors to apply for the buy-in at the same time as they apply for Social Security and Medicare. Furthermore, Social Security offices are often in locations that are safer and easier to reach by public transportation than local Medicaid offices.

To date, the two most relevant agencies in the Department of Health and Human Services—the Health Care Financing Administration (HCFA) and the Social Security Administration (SSA)—have not acted on these proposals and have opposed legislation mandating such a change. Taking applications at Social Security offices is an example of a strategy that the President is proposing to achieve high participation in his health insurance voucher program, but opposes to increase the participation of poor seniors in the buy-in program.

The Congressional proposals also make provisions for seniors to apply for the buy-in by mail and for a streamlined application or request for application.

- **Annual notices**

Many Members of Congress have proposed that the Department of Health and Human Services notify Medicare beneficiaries each year about the buy-in benefit; about the eligibility requirements for the benefit; and about where to apply for the

benefit. To date, HCFA has refused to commit to regular notices. In the ***1992 Guide To Health Insurance for People with Medicare***, developed jointly by HCFA and the National Association of Insurance Commissioners, the buy-in is not mentioned until page 19.

- **Toll-free number, outreach**

Many Members of Congress are asking for a toll-free number to call for information about the buy-in benefit. Several Congressional proposals authorize outreach programs to identify and enroll eligible persons. To date, HCFA has refused to act on these proposals.

- **Retroactivity**

Many Members of Congress have recognized the inequities that have resulted from the lack of information about the buy-in benefit. Some Members have proposed that beneficiaries who newly learn about the buy-in benefit and apply within a specified enrollment period be eligible for retroactive benefits as if they had applied when first eligible.

In addition, many Members have recognized that QMBs should be treated the same as other categories of Medicaid beneficiaries and be allowed to get benefits retroactive to three months from the date of application.

HCFA opposes these proposals.

- **Using providers to reach eligible seniors and using presumptive eligibility**

A potentially effective way of reaching eligible QMBs is when they are seeking medical care and incurring medical expenses—at a doctor's office or a hospital. Many of the Congressional proposals recognize the importance of providing better information to potential QMBs through providers.

Recently, Congress has sought to increase the numbers of pregnant women getting Medicaid benefits by allowing providers to provisionally enroll likely beneficiaries (a procedure known as "presumptive eligibility"). The potential beneficiary then has 60 days to file a formal application. Members of Congress have proposed that the numbers of QMBs be increased by allowing providers to presumptively enroll potential QMBs.

To date, HCFA has not involved providers of health care in systematic QMB outreach efforts by, for example, sending notices for posting in offices. Moreover, HCFA opposes the use of presumptive eligibility for likely QMBs. These are other examples of strategies that President Bush proposes as part of providing vouchers under his Comprehensive Health Reform Program, but opposes for the poor elderly.

■ **Part A enrollment**

HCFA can identify approximately 337,000 individuals who do not have Medicare hospitalization benefits, but are eligible to have the Medicaid program pay their Medicare Part A premiums ($192 a month). These are generally very low-income seniors or persons with disabilities who do not have enough of a work history to be automatically eligible for Medicare hospitalization benefits. Many states are not providing these very low-income persons with the more comprehensive Medicare hospitalization benefits. One key Congressional proposal would clarify that it is mandatory for states to buy QMBs into Medicare Part A, if they do not already have the coverage.

Endnotes

1. As of 1992 physicians may charge Medicare beneficiaries up to 120 percent of the Medicare-allowed charge, and the beneficiary is solely responsible for the additional 20 percent of the charge.

2. Congress repealed most of the Medicare Catastrophic Coverage Act in 1989 but left in place the provisions requiring financial protection from Medicare out-of-pocket costs for low-income Medicare beneficiaries.

3. The law orginally allowed six states, known as 209(b) states, to use an income eligibility standard five percent lower than the national standard for four years. These states were required to use an income eligibility standard for the buy-in equal to 100 percent of the poverty guideline as of January 1, 1992.

4. In the following states Medicaid hospitalization benefits are more limited than Medicare hospitalization benefits according to the latest state plan information in Commerce Clearing House's **Medicare and Medicaid Guide**: Alabama, Arkansas, Idaho, Kentucky, Louisiana, Mississippi, Ohio, Oklahoma, Oregon, Tennessee, Texas, Virginia and West Virginia.

TABLE 1
ELDERLY POOR PERSONS WITHOUT MEDICARE BUY-IN BENEFITS
MARCH, 1992

	Estimated Number of Non-Institutionalized Poor Seniors Meeting Buy-In Criteria	Estimated Number of Non-Institutionalized Buy-Ins	Estimated Number of Eligible Non-Institutionalized Seniors Without Buy-In Benefits	Estimated Percent of Eligible Non-Institutionalized Seniors Without Buy-In Benefits
UNITED STATES	4,246,363	2,230,026	2,016,337	47%
Alabama	130,748	84,679	46,069	35%
Alaska	3,526	87	3,439	98%
Arizona	42,481	30,656	11,825	28%
Arkansas	90,755	38,407	52,348	58%
California	252,741	35,118	217,623	86%
Colorado	34,403	20,343	14,060	41%
Connecticut	43,789	21,528	22,261	51%
Delaware	10,428	3,462	6,966	67%
District of Columbia	15,824	7,180	8,644	55%
Florida	231,401	128,267	103,134	45%
Georgia	188,987	63,193	125,794	67%
Hawaii	21,839	8,197	13,642	62%
Idaho	12,606	5,550	7,056	56%
Illinois	172,994	80,390	92,604	54%
Indiana	64,968	22,690	42,278	65%
Iowa	41,300	17,824	23,476	57%
Kansas	38,927	9,643	29,284	75%
Kentucky	90,278	60,529	29,749	33%
Louisiana	106,048	72,728	33,320	31%
Maine	22,209	20,048	2,161	10%
Maryland	67,875	40,893	26,982	40%
Massachusetts	77,152	34,744	42,408	55%
Michigan	111,016	45,589	65,427	59%
Minnesota	55,718	34,649	21,069	38%
Mississippi	105,243	69,817	35,426	34%
Missouri	99,030	57,358	41,672	42%
Montana	10,601	3,457	7,144	67%
Nebraska	26,175	8,597	17,578	67%
Nevada	10,880	7,531	3,349	31%
New Hampshire	9,564	3,563	6,001	63%
New Jersey	130,675	80,266	50,409	39%
New Mexico	30,138	18,804	11,334	38%
New York	364,458	210,473	153,985	42%
North Carolina	179,140	96,567	82,573	46%
North Dakota	12,444	3,594	8,850	71%
Ohio	138,551	65,953	72,598	52%
Oklahoma	65,327	53,501	11,826	18%
Oregon	32,982	18,713	14,269	43%
Pennsylvania	219,293	98,039	121,254	55%
Rhode Island	18,405	5,883	12,522	68%
South Carolina	90,879	51,966	38,913	43%
South Dakota	14,284	7,373	6,911	48%
Tennessee	159,594	96,414	63,180	40%
Texas	323,519	207,256	116,263	36%
Utah	13,577	7,500	6,077	45%
Vermont	8,023	7,321	702	9%
Virginia	105,832	59,986	45,846	43%
Washington	37,251	37,251	0	0%
West Virginia	52,393	23,901	28,492	54%
Wisconsin	55,310	40,214	15,096	27%
Wyoming	4,782	2,336	2,446	51%

TABLE 2
PERCENT CHANGE IN NON-INSTITUTIONALIZED ELDERLY BOUGHT IN SINCE MAY 1991

	Change in Estimated Number of Non-Institutionalized Buy-Ins	Percentage Difference In Estimated Number of Non-Institutionalized Eligibles Bought In
UNITED STATES	151,666	3.6%
Alabama	5,726	4.4%
Alaska	5	0.1%
Arizona	1,789	4.2%
Arkansas	2,682	3.0%
California	7,830	3.1%
Colorado	1,152	3.3%
Connecticut	2,527	5.8%
Deleware	261	2.5%
District of Columbia	91	0.6%
Florida	5,847	2.5%
Georgia	4,215	2.2%
Hawaii	382	1.7%
Idaho	934	7.4%
Illinois	9,811	5.7%
Indiana	2,057	3.2%
Iowa	1,457	3.5%
Kansas	516	1.3%
Kentucky	2,997	3.3%
Louisiana	5,439	5.1%
Maine	1,398	6.3%
Maryland	2,346	3.5%
Massachusetts	1,064	1.4%
Michigan	5,124	4.6%
Minnesota	2,887	5.2%
Mississippi	2,184	2.1%
Missouri	3,710	3.7%
Montana	(351)	-3.3%
Nebraska	1,074	4.1%
Nevada	583	5.4%
New Hampshire	453	4.7%
New Jersey	3,809	2.9%
New Mexico	685	2.3%
New York	7,777	2.1%
North Carolina	9,117	5.1%
North Dakota	178	1.4%
Ohio	4,950	3.6%
Oklahoma	2,872	4.4%
Oregon	2,803	8.5%
Pennsylvania	4,337	2.0%
Rhode Island	819	4.5%
South Carolina	3,288	3.6%
South Dakota	647	4.5%
Tennessee	7,517	4.7%
Texas	15,359	4.7%
Utah	1,639	12.1%
Vermont	710	8.9%
Virginia	5,001	4.7%
Washington	0	0.0%
West Virginia	2,744	5.2%
Wisconsin	998	1.8%
Wyoming	221	4.6%

Technical Appendix

TECHNICAL APPENDIX

This technical appendix presents the steps completed in order to estimate a participation rate for Medicare Buy-ins (known as Qualified Medicare Beneficiaries - QMBs) by state. One participation rate was estimated. This differs from a previous report based on May 1991 data where estimates were presented as a range. The simplification of the methodology is discussed in Section III. To calculate participation rates, the eligible population and the number of buy-ins had to be estimated.

In the participation rate for all non-institutionalized elderly persons bought into Medicare, the numerator includes all non-institutionalized elderly persons who meet certain income and asset criteria who were bought into the Medicare program, including those receiving other Medicaid benefits, and the denominator includes all non-institutionalized elderly persons who meet the income and asset criteria.

I. ELIGIBLE POPULATION

The first task was to estimate the population meeting the income and asset criteria for the denominators of the participation rates discussed above. State-by-state estimates of the number of non-institutionalized elderly persons with income below the poverty guideline in 1992 were estimated using data from a pooled data base of four years of March Current Population Survey (CPS) data. These estimates differ from the Bureau of the Census estimates of the number of individuals in poverty for two reasons:

- The income thresholds used in these estimates were based on the poverty guidelines published in the February 14, 1992 Federal Register. The poverty guidelines are a simplified version of the Federal Government's statistical poverty thresholds used by the Bureau of the Census to prepare its statistical estimates of the number of persons and families in poverty. The poverty income guidelines are issued by the Department of Health and Human Services to be used for administrative purposes, such as determining whether a person or family is financially eligible for assistance or services under a particular Federal program. Unlike the poverty threshold used for statistical purposes, the poverty guidelines are not age dependent. The poverty guidelines for 1992 are $6,810 for single persons ($8,500 in Alaska and $7,830 in Hawaii) and $9,190 for two person families ($11,480 in

Alaska and $10,570 in Hawaii). In comparison, the poverty thresholds in 1992 are projected to be approximately $6,720 for a single person age 65 and over and $8,475 for a couple age 65 and over.

- The definition of income used for these estimates differs from that used by the Bureau of the Census when they define income as a percent of the poverty level. The Census Bureau includes the income of all members of a family in determining income as a percent of the poverty level. In calculating income as a percent of the poverty guideline for these estimates, only the income of the spouses of a married couple where at least one member is age 65 or older and only the income for single individuals for persons age 65 and over were used.

In addition to an income criteria, buy-ins must meet an asset criterion; countable assets less than $4,000 for single persons and less than $6,000 for married persons. Using a national estimate of the percent of single and married persons below the countable asset criteria from the 1984 SIPP (adjusted to 1992), we adjusted the population below the poverty guideline for each state.

II. MEDICARE BUY-INS

Estimates of Medicare buy-ins were provided for March 1992 by the Health Care Financing Administration (HCFA) Bureau of Data Management and Strategy (BDMS). These estimates included certain groups not captured in the eligible population estimates discussed above. In order to estimate an accurate participation rate, some of the groups needed to be excluded from the buy-in estimates. Two groups that needed to be taken out were elderly buy-ins who are institutionalized and persons under age 65 who qualify for Medicare on the basis of a disability and have income less than the poverty guideline. Data from fiscal year 1989 Medicaid 2082 forms, the latest complete information available, were used to adjust the estimates of the number of buy-ins as discussed below.[1]

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[1] Adjustments were not made to buy-in data for Arizona because the state did not report Medicaid data from the 2082 forms for Fiscal Year 1989.

A. Institutionalized

In order to exclude the institutionalized persons from the buy-in estimates, the percentage of elderly Medicaid beneficiaries who use care provided in an Intermediate Care Facility other than one for the Mentally Retarded (ICF other) was calculated for each state[2] and the percentage subtracted from the number of buy-ins. Elderly persons receiving care from ICF Other care, rather than ICF/MR or SNF services, were used to approximate the percentage of Medicaid buy-ins who were institutionalized because this category would be less likely to double count persons moving in and out of facilities.

All institutional categorical eligibles receiving cash assistance were subtracted from the buy-in estimates. Other institutionalized non-cash beneficiaries were subtracted in states that also bought in non-cash recipients. Percentages by state were used, rather than actual numbers because the Medicaid data are for 1989 and the estimates are based on persons receiving Medicaid during the course of the year, not at one point in time.

B. Disabled Non-Elderly

In order to exclude the disabled non-elderly who are bought in, a national estimate of the number of under 65 disabled who are Medicare and Medicaid eligible and have income less than the poverty guideline was required. We assumed that all disabled persons under age 65 receiving Medicaid and Medicare have income less than the poverty guideline by virtue of the work-related disability requirements tied to SSI. Based on an estimate from HCFA's Office of Research and Demonstrations (ORD) (Medicaid Source Book: Background Data and Analyses, November 1988, p. 142), we assumed that 20 percent of Medicaid disabled beneficiaries are also eligible for Medicare. 1989 estimates

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[2] The numerator and denominator for the percentage differed dependent upon whether a state buys-in its non-cash recipients. If non-cash recipients are bought in they were included in the numerator and the denominator and a further adjustment described in a later section was also performed.

of Medicaid disabled beneficiaries from 2082 data by state were used, multiplied by 20 percent and then updated to 1991. These estimates were subtracted from the buy-in estimates.

C. Others

In three states, Alaska, California, and Massachusetts, the percent of Medicaid recipients who receive cash assistance were also excluded from the estimates of the number of buy-ins because the SSI payments, with state supplementation, for singles and couples is greater than the poverty guideline. In California, all Medically Needy recipients were excluded from the estimates of buy-ins because the Medically Needy income limit in that state is above the poverty guideline for both singles and couples. (Vermont also has Medically Needy income limits above the poverty guideline, but does not buy in its Medically Needy recipients.)

III. REESTIMATION OF MAY 1991 RESULTS

This report presents results based on HCFA estimates fo. May 1991 that differ slightly from the previous report. The major difference in the estimates is that a range is no longer presented. The previous report presented a range because it was unclear in which instances persons eligible for Medicare Buy-In benefits on the basis of Medically Needy eligibility criteria may have had income greater than the poverty guideline. Therefore, a range, including and excluding an estimate of the Medically Needy population in states that bought in their Medically Needy eligibles was provided.

Since the first report, states that were contacted indicated that all Medicare buy-ins reported to HCFA met the income and asset criteria for eligibility. Therefore, we no longer present a range.

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